		(X2) MULTIPLE CO		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155656	B. WING		02/09/2012	
NAME OF I	PROVIDER OR SUPPLIE	D.	STREET	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	ROVIDER OR SOLI EIE	IX.	2827 N	ORTHGATE BLVD		
CANTER	RBURY NURSING	AND REHABILITATION CENTER	FORT	WAYNE, IN 46835		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0000						
			F0000	Danagaria and tanagaria	- £	
		or the investigation of	F0000	Preparation and/or execution this plan of correction does no		
	Complaint IN00	0103433.		constitute admission or		
		)102422 G 1		agreement by the provider of	the	
	_	0103433-Substantiated.		truth of the facts alleged or		
		ficiencies related to the		conclusions set forth in the statement of deficiencies. Thi		
	_	eited at F 157, F279, F327,		Plan of Correction is prepared		
	F328			and/or executed solely because		
				is required by the provision of		
	Unrelated deficiency is cited.			federal and state law.We	,	
				respectfully requeset this Plan Correction serve as our allega		
	Survey dates: Fo	ebruary 7, 8, 9, 2012		of compliance effective March		
				6th, 2012.		
	Facility number	: 000275				
	Provider numbe	er: 155656				
	AIM number: 1	00290930				
	Survey team:					
	Ann Armey, RN	N				
	Census bed type	2:				
	SNF/NF: 103					
	Residential: 12					
	Total: 115					
	Census payor ty	vpe:				
	Medicare: 13	1				
	Medicaid: 72					
	Other: 30					
	Total: 115					
	113					
	Sample: 5					
	Sumple. 3					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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VNUZ11

000275

PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155656	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMPLETED 02/09/2012		
	PROVIDER OR SUPPLIER RBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.					
	Quality review completed on February 14, 2012, by Bev Faulkner,RN					
	•					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION  00	(X3) DATE SURVEY COMPLETED 02/09/2012	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET 2827 N	ADDRESS, CITY, STATE, ZIP CODE IORTHGATE BLVD WAYNE, IN 46835	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0157 SS=D	A facility must im resident; consult and if known, no representative or member when the resident which the potential for intervention; a si resident's physic status (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483.  The facility must resident and, if k representative or when there is a classing as change in resident and paragraph (b)(1). The facility must update the addresserver in the resident and the res	NE/ROOM, ETC) Immediately inform the with the resident's physician; tify the resident's legal ran interested family Idere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial reforation in health, mental, retatus in either life litions or clinical raneed to alter treatment raneed to discontinue an reatment due to adverse or to commence a new form reatment due to adverse or to commence a new form reatment from the facility as 3.12(a).  also promptly notify the nown, the resident's legal rinterested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in			
	Based on intervious facility failed to care representative change in the res	ew and record review, the notify a resident's health we when there was a ident's condition. This ed 1 of 5 residents	F0157	It is the policy of this facility to notify a resident's healthcare representative when there are changes in conditions.  (1)Corrective Action for reside found to be affected by alleger	nt

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLE	ETED
		155656	B. WIN			02/09/2	2012
					ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	PROVIDER OR SUPPLIEI	₹			ORTHGATE BLVD		
CANTER	BURY NURSING A	AND REHABILITATION CENTER			WAYNE, IN 46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	reviewed for notification, in a sample of				deficient practice: Resident B longer resides at the facility.(2		
	5. (Resident #B)				Identification of other residents		
					having potential to be affected		
	Findings include	<del>:</del>			alleged deficient practice: A o	-	
					time audit completed for curre		
	The closed clinic	cal record of Resident #B			resident population to validate		
		1 2/7/12 at 2:30 p.m., and			contact information, whether it		
		ident was admitted to the			the resident themself, or other as designated at time of	S,	
		2 and was discharged to			admission. Staff have been		
	the hospital on 1	_			re-educated on the		
	l the nospital on i	/22/12.			resident-family notification		
	D //Di C.				process in the event of a		
		ce sheet indicated the			condition change.(3) Measure		
		ry contact was her son.			place to ensure alleged deficiently practice does not recur: The	ent	
		ed as the resident's			Charge nurses will be respons	sible	
	Durable Power of	•			to notify residents and families		
	document signed	d by the resident, dated on			condition changes as they occ		
	11/5/11 and nota	rized on 1/27/11. The			Charge nurses will be respons	sible	
	Power of Attorn	ey document granted			to confirm the health care		
	fiduciary, financ	ial and business powers			representative status at time of change in condition by visual	OT	
	to the son but di	d not specify that the son			validation of the resident's face	e l	
	would have heal				sheet information.		
		1			Documentation will be made in	า	
	A second docum	nent, in a file provided by			the resident's medical file to		
		or on 2/8/12, indicated the			provide confirmation that the		
		ointed a daughter as her			family member who is listed as the healthcare representative		
		presentative on 10/13/11.			been notified The face shee		
	_				information will be reviewed in		
		vas signed by the resident.			person with the resident and/o		
	and withessed by	y another individual.			their family member during the	•	
					quarterly care plans.(4)How system will be monitored to		
	I -	ho was named as the			ensure alleged deficient practi	ce	
	_	resentative was not listed			does not recur: The nurse	·	
	on the face sheet	t in the closed clinical			managers/designee will be		
	record.				responsible to audit reported		
					condition changes daily for 14		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITH DI	DIC.	00	COMPL	ETED
		155656	A. BUILDI	ING		02/09/	2012
			B. WING	CTDEET A	DDDESS CITY STATE ZID CODE		
NAME OF I	PROVIDER OR SUPPLIE	IR.			ADDRESS, CITY, STATE, ZIP CODE		
CANTER	DDI IDV NII IDQING	AND REHABILITATION CENTER			ORTHGATE BLVD VAYNE, IN 46835		
			<u>.                                      </u>		VATINE, IN 40033		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	NCY MUST BE PERCEDED BY FULL		REFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	1	TAG	DEFICIENCY)		DATE
		1:00 a.m., the physician			days, the wkly for 8 weeks, an then 5 random reviews monthly		
	was notified abo	out a decline in Resident			for 6 months to ensure that	у	
	#B's level of con	nsciousness and increased			appropriate notification has be	en	
	confusion.				made regarding the condition	· · ·	
	On 1/19/12 at 2	:15 p.m., nursing notes			change. Any identified issues		
		sident's son was aware of			with non-compliance of		
	all new orders b				notification per facility policy w	ill	
	documentation				be addressed through 1:1 education and/or disciplinary		
		vas notified about the			actions. Audit results will be		
	resident's chang				reviewed monthly at CQI and	will	
	l resident's chang	e of condition.			be discontinued after 6 months	s if	
	T :1 /	. 1 1.4 1 6.11			there are no identified trends of	of	
		indicated the resident fell			non-compliance.		
		1/12, 1/20/12 and 1/18/12.					
	•	ports indicated the son was					
	notified regarding	ng the falls but the					
	daughter, who v	vas the health care					
	representative, v	was not notified.					
	On 1/22/12 at 1	2:00 p.m. and 1/17/12 at					
	1:45 p.m., nurs	ing notes indicated the					
	resident had abr	normal laboratory test					
		vsician/nurse practitioner					
		nd the son was notified,					
	1	locumentation the health					
		ive was notified about the					
	_	atory test results.					
		nory test results.					
	On 2/7/12 at 4:0	00 n m   I DN #10					
	On 2/7/12 at 4:00 p.m., LPN #10, who was the nurse on Resident B's hall, was interviewed and indicated she contacted						
		n frequently and kept him					
	updated on Resi	ident #B's condition.					
	On 2/8/12 at 12	:00 p.m., the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A DUBLING 00			(X3) DATE SURVEY  COMPLETED		
ANDILAN	OI CORRECTION	155656	A. BUII			02/09/	
		100000	B. WIN			02/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				DDRESS, CITY, STATE, ZIP CODE		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			DRTHGATE BLVD VAYNE, IN 46835		
(X4) ID		FATEMENT OF DEFICIENCIES	<del></del>	ID			(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	DATE
	Administrator in	dicated the son was					
		primary contact because					
	_	ole Power of Attorney.					
		or indicated the Durable					
	Power of Attorne	ey document was dated					
	11/5/11, while th	-					
		ocument was dated					
	•	sult, the Durable Power					
	-	hority was felt to be the					
	_	e Administrator indicated					
	typically the faci	lity designates one					
	person as a prima						
	Administrator in	dicated the son					
	accompanied the	resident at the time of					
	-	lled out some of the					
	admission paper	work. Finally, the					
		dicated the staff were					
	never instructed	by the son or Resident					
	#B to call the res	_					
	regarding health	<del>-</del>					
	This Federal tag	relates to Complaint					
	IN00103433.	•					
	3.1-5(a)(1)						
	3.1-5(a)(2)						
	3.1-5(a)(3)						
			1				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUIL DDIG	00	COMPLETED
		155656	A. BUILDING		02/09/2012
			B. WING	A DDDDGG CHTM CTATE TIP CODE	
NAME OF P	ROVIDER OR SUPPLIE	R		ADDRESS, CITY, STATE, ZIP CODE	
				ORTHGATE BLVD	
CANTER	BURY NURSING A	AND REHABILITATION CENTER	FORT	WAYNE, IN 46835	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0279 SS=D	PLANS	IPREHENSIVE CARE			
		se the results of the			
		develop, review and revise the			
	resident's comp	rehensive plan of care.			
	care plan for ea measurable objumeet a resident mental and psyd identified in the	t develop a comprehensive ch resident that includes ectives and timetables to s medical, nursing, and chosocial needs that are comprehensive assessment.			
	are to be furnish resident's highe mental, and psy required under { that would other §483.25 but are resident's exerc	nust describe the services that ned to attain or maintain the st practicable physical, chosocial well-being as §483.25; and any services wise be required under not provided due to the ise of rights under §483.10, ht to refuse treatment under			
	facility failed to care plan with in resident develop of dehydration. of 3 residents widehydration in a #B)  Findings include The closed clinic was reviewed or	lew and record review, the develop an individualized aterventions when a led risk factors and signs. This deficiency affected 1 ho were reviewed for sample of 5. (Resident let:  cal record of Resident # B in 2/7/12 at 2:30 p.m., and sident had been admitted	F0279	It is the practice of this facility develop individualized care play with interventions when resided develop risk factors and signs dehydration.(1) Corrective Act for alleged deficient practice: Resident B no longer resides at the facility.(2) Identification of other potential areas affected alleged deficient practice: A otime audit has been completed for current resident population reviewing for any resident with diarrhea, nausea/vomiting or change in mental status. Show any resident be identified with above symptoms, action(s) show the staken to include MD/Family	ans ents of ion at by one d uld the

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED	
		155656	1			02/09/2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹					
OANTED		AND DELIABILITATION OF SITED			ORTHGATE BLVD		
CANTER	CANTERBURY NURSING AND REHABILITATION CENTER			FORT	VAYNE, IN 46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETI	ON
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	to the facility from	om the hospital on 1/4/12,			notification, change in plan of		
	with diagnoses v	which included but were			care, etc. The staff have been		
		nronic biventricular			re-educated on the care plann		
	· ·				process, which includes updat	ng	
		failure, diabetes mellitus,			the care plans as condition		
	1	obesity and chronic renal			changes arise, and		
	insufficiency.				implementation of new interventions as determined		
	The resident was	s discharged to the			necessary based on		
	hospital on 1/22/	/12.			interdisciplinary review and		
	1				individual resident needs.		
	Admission orders, dated 1/4/12, indicated				(3)Systematic change to ensur	e	
					alleged deficient practice does		
		to receive, among other			not recur: It is the responsibili	y	
	medications:				of the Interdisciplinary Team to	)	
	Spironolactone/A	Aldactone (a diuretic			review and update the plans o		
	medication) 25 r	ng every day,			care. Should a resident have	a	
		retic medication) 40 mg			noted condition change with		
	twice daily and	in the same and the same			nausea, vomiting, diarrhea, an		
	l				cognitive changes, said reside will be brought forward for the		
	` *	ium supplement) 40 mg			review to assist with identificat		
	every day.				of new interventions to be		
					implemented, resident/family		
	Dehydration was	s not identified as a			notification and education, as	vell	
	trigger on the 1/2	11/12, RAI (Resident			as MD notificiation. The Nurse		
	Assessment Inst				Supervisors/designee will be		
	Tibbeblie in the	rumont).			responsible to review current		
	01/16/12 (1)	DD (D : - t 1			resident population following a		
	On 1/16/12, the	· -			noted condition change of nau	sea	
	· · · · · · · · · · · · · · · · · · ·	sed Resident #B's			and vomiting, diarrhea, and		
	nutritional status	s. The RD's progress			mental status changes daily fo		
	notes, dated 1/16	5/12, indicated, among			14 days, wkly for 8 wks, and the random reviews monthly for 6	e o	
	other things, that	t the resident's estimated			months. In addition, the IDT		
		s were 3250 ccs to 3900			team will review residents with		
	ccs.				noted diarrhea, nausea.vomitir	ıg,	
		the and also mentals at the a			and/or mental status changes	<u> </u>	
		licated the resident's diet			daily, Mon through Friday, for	60	
		pedside provided the			days, wkly for 12 weeks, and t		
	resident's with he	er estimated fluid needs.			5 random reviews monthly for	6	
					months to ensure new		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED			COMPLETED
		155656	B. WIN			02/09/2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	₹			ORTHGATE BLVD	
CANTER	BURY NURSING A	AND REHABILITATION CENTER			VAYNE, IN 46835	
(X4) ID		TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	TE	
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
		re plan was initiated, on			interventions are identified and	
	1/16/12, and deh	nydration was not			implemented for resident care Any identified issue with non	•
	identified as an a	assessed problem but one			compliance in resident/family	
	of the nutritional	l goals was for the			notification as per policy and	
	resident to be fre	ee of dehydration.			procedure will result in 1:1	
		care plan interventions			re-education and/or discplinary	
	included the foll				action.(4) How Corrective Action	
	Provide diet as o	•			of Alleged deficient practice w be monitored: The	III
	Honor food prefe				ADM/Designee will be	
	Monitor intake of meals and offer alternates as needed.  Vitamins and minerals as ordered				responsible to review the resu	lts
					of the monitoring process and	
					forward said reviews to the QA	
					Committee for monthly review	
	(multivitamin an	-			and discussion for 3 months a then quarterly review for 3	na
	Monitor weights				quarters. Any further action	
	Encourage fluids	s unless contraindicated,			necessary will be as determine	ed
	and				by the QA committee.Addedur	
	Monitor labs and	d monitor for signs and			for request on 3-6-12: A care	
	symptoms of hyp	po/hyperglycemia.			plan will be implemented for	
					residents who require use of a diuretic at the time the order is	
	On 1/17/12, a Bi	MP (Basic Metabolic			recieved by the charge nurse	'
	Panel) for Reside	ent # B, indicated the			Treesers and the change have	
	/	vated potassium, BUN				
	and creatinine le	_				
		vel was high at 5.4				
	(normal range 3.	•				
		gen level was high at 79				
	1					
	(normal range of	-				
		vel was high at 3.0				
	(normal range of	1 0.6-1.3).				
ı	On 1/17/12 at 1:	45 p.m., nursing notes				
		urse Practitioner was				
	<b>'</b>					
		e abnormal laboratory				
	results and the D	Demadex and K-Dur				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 CO			(X3) DATE S COMPLE	ETED	
		155656	B. WIN	G		02/09/2	2012
NAME OF P	PROVIDER OR SUPPLIER	₹			ADDRESS, CITY, STATE, ZIP CODE		
CANTER	BURY NURSING A	AND REHABILITATION CENTER			ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION PR FFIX (EACH CORRECTIVE ACTION SHOULD BE				(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL  LISC IDENTIFYING INFORMATION)		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		TE	COMPLETION DATE
1710	dosages were red			1710		-	DATE
	~	s,dated 1/17/12, indicated					
	1 -	as reduced to 30 mgms					
		e Demadex was reduced					
	to 30 mgms twic						
		aboratory test was ordered					
	to be done in a w	•					
	On 1/18/12 at 2:	20 p.m., nursing notes					
	indicated the resident had one loose stool						
	and an episode of dry heaves.						
	On 1/19/12 at 11	:00 a.m., a SBAR					
	physician/nurse	_					
		and progress note					
		ident's condition had a					
		/17/12 and she was					
		reased confusion, an					
		nd a decrease in the level					
	of consciousness	5.					
	0 1/10/10 1	D1 ' ' 1 1					
		Physician ordered a					
	_	ergan as needed for					
		odium as needed for					
	diarrhea.						
	On 1/20/12 at 10	0:00 p.m., nursing notes					
		ident had a small loose					
	stool and a fall v						
	Stoor and a rail v	· · · · · · · · · · · · · · · · · · ·					
	On 1/21/12 at 9:	50 a.m., the resident had					
		diarrhea" and Immodium					
		note indicated they were					
	_	the urine specimen					

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Event ID: VNUZ11

Facility ID: 000275

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IES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155656	(X2) MULTIPLE CO  A. BUILDING  B. WING	00	(X3) DATE SURVEY COMPLETED 02/09/2012
	2827 N	ORTHGATE BLVD	
FICIENCY MUST BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE COMPLETION
urine was contaminated with			
travenous fluids were ordered ree attempts staff were unable cess. The resident's son was put the order for intravenous redicated to be careful because experienced fluid overload in the care unit. The dicated a urine specimen was estraight catheterization and obtained."  The indicated the Nurse was notified regarding critical rest results and ordered the retained to the			
report, dated 1/22/11, indicated s: evel was "panic high" at 6.6 ge 3.6-5.1), mitrogen level was "panic 7 (normal range of 7-18) and ne level was high at 7.2 ge of 0.6-1.3).  transfer form, dated 1/22/12 ted) indicated the resident had			
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: 155656  PPLIER  NG AND REHABILITATION CENTER  ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PERCEDED BY FULL REY OR LSC IDENTIFYING INFORMATION)  Turine was contaminated with  at 12:00 p.m., nursing notes stravenous fluids were ordered ree attempts staff were unable cess. The resident's son was but the order for intravenous adicated to be careful because experienced fluid overload in e e care unit. dicated a urine specimen was restraight catheterization and obtained."  rither indicated the Nurse rewas notified regarding critical est results and ordered the bet transported to the room.  Basic Metabolic Panel) report, dated 1/22/11, indicated s: evel was "panic high" at 6.6 age 3.6-5.1), nitrogen level was "panic 7 (normal range of 7-18) and and level was high at 7.2 age of 0.6-1.3).  transfer form, dated 1/22/12 ted) indicated the resident had a for three days, a decreased	IDENTIFICATION NUMBER: 155656  TOTAL STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD FORT WAYNE, IN 46835  ARY STATEMENT OF DEFICIENCIES FICIENCY MUST BE PERCEDED BY FULL RY OR LSC IDENTIFYING INFORMATION)  Turine was contaminated with  at 12:00 p.m., nursing notes stravenous fluids were ordered ree attempts staff were unable cess. The resident's son was but the order for intravenous dicated to be careful because experienced fluid overload in e care unit. dicated a urine specimen was straight catheterization and obtained."  Their indicated the Nurse was notified regarding critical est results and ordered the be transported to the room.  Basic Metabolic Panel) eport, dated 1/22/11, indicated s: evel was "panic high" at 6.6 gg 3.6-5.1), nitrogen level was "panic 7 (normal range of 7-18) and ne level was high at 7.2 gg of 0.6-1.3).  transfer form, dated 1/22/12 ted) indicated the resident had for three days, a decreased

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING  00			(X3) DATE S COMPL	ETED	
		155656	B. WING	G		02/09/	2012
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER		2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	laboratory test re	esults.					
	1/22/12, indicate cardiac arrest en room and was pu arrival at the emindicated the reshad a spontaneou. The note further she has become	ncy room records, dated and the resident had a route to the emergency alseless and apneic upon ergency room. The record ident was intubated and us return of circulation. indicate "I suspect that dehydrated which has cute renal failure and the cause of her					
	1/22/12, indicate following: "1. Acute kidney secondary to a co	altation report, dated and Resident #B had the vinjury and hyperkalemia combination of volume diarrhea and concomitant herapy, including					
	signs of dehydra change in menta laboratory values there was no doc comprehensive of hydration or the was developed.	s and low urine output,					

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PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CON	NSTRUCTION 00	(X3) DATE SURVEY  COMPLETED			
11.1211111	155656	A. BUILDING		02/09/2012			
		B. WING STREET A	DDRESS, CITY, STATE, ZIP CODE				
NAME OF I	PROVIDER OR SUPPLIER	2827 NORTHGATE BLVD					
CANTER	RBURY NURSING AND REHABILITATION CENTER	FORT W	/AYNE, IN 46835				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCT)	DATE			
	(Director of Nursing) was interviewed. The DON indicated a specific care plan						
	for hydration/dehydration was not						
	developed and the nutritional careplan						
	was not updated. The DON indicated they						
	continued with the exiting nutritional						
	interventions previously care planned and						
	the physician or nurse practitioner were						
	notified when the resident experienced						
	changes and orders were obtained to						
	address each concern.						
	address each concern.						
	The policy for the nutrition and hydration						
	program, effective 4/2010, provided by						
	the DON, was reviewed on 2/9/12 at						
	10:00 a.m., and indicated "Monitor the						
	resident for factors that put the resident at						
	risk of dehydration. These may include						
	but are not limited to:						
	Diarrhea						
	Diuretic medications						
	Renal disease						
	b.) If new risk factors are identified, new						
	interventions will be implemented and						
	appropriate clinicians will be notified for						
	further assessments						
	5. Assess for clinical sign/symptoms of						
	insufficient fluid intake including, but not						
	limited to:						
	Acute confusion						
	Change in mental status						
	Deteriorated cognitive status						
	Elevated laboratory values						
	Low urine output						

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PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155656	(X2) MULTIPLE CON  A. BUILDING  B. WING	00	COMPLETED 02/09/2012			
	PROVIDER OR SUPPLIER BURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2827 NORTHGATE BLVD					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE			
	7. Implement individualized interventions based on resident needs"						
	This Federal tag relates to Complaint IN00103433.						
	3.1-35(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR A. BUILDING (COMPLETE					
		155656	A. BUII B. WIN			02/09/	2012
	PROVIDER OR SUPPLIE	R AND REHABILITATION CENTER		2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD NAYNE, IN 46835		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0327 SS=D	HYDRATION The facility muss sufficient fluid in hydration and he Based on intervithe facility faile individualized owhen a resident and signs of defaffected 1 of 3 reviewed for defected the facility fluid was reviewed or indicated the resident was reviewed or indicated the resident with diagnoses not limited to, congestive heart seizure disorder insufficiency. The resident was hospital on 1/22 Admission order the resident was medications:  Spironolactone/medication) 25 for the facility fluid in the resident was medications:	iew, and record review, d to re-assess and develop are plan interventions developed risk factors advised by the sidents who were sidents who were hydration in a sample of 5.  e:  cal record of Resident # B at 2/7/12 at 2:30 p.m., and sident had been admitted from the hospital on 1/4/12, which included but were thronic biventricular at failure, diabetes mellitus, and so discharged to the sident hydration to the sident hydration and chronic renal as discharged to the sident hydration and chronic renal at a discharged to the sident hydration and the sident hydration and chronic renal at a discharged to the sident hydration and sident hydration and chronic renal at a discharged to the sident hydration and sident hydration and sident hydration are sident hydration.	F03	27	It is the facility's policy to asse and develop individualized car plan internventions when a resident develops risk factors signs of dehydration.(1) Corrective Action: Resident b longer resides at the center(2) Identification of Other resident with potential to be affected by alleged deficient practice: A o time audit has been completed for current resident population reviewing for any residents wit diarrhea, nausea/vomiting, or change in mental status. Any identified symptoms will be reported to the attending physician and notification will be updated to reflect the change condition.(3) Systematic change to ensure that alleged deficien practice does not recur: The swere re-educated ont he care planning process. which included the plans of the interventions as determined necessary based on interdisciplinary review and individual resident needs. It is responsibility of the IDT team review and update the plans of	and no s ne d th  pe t staff des	03/06/2012

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			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155656	B. WINC			02/09/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			ORTHGATE BLVD		
CANTER	RBURY NURSING A	AND REHABILITATION CENTER			VAYNE, IN 46835		
(X4) ID	SUMMARYS	STATEMENT OF DEFICIENCIES		ID		(X5)	
PREFIX		NCY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTION  DD FFIY  (EACH CORRECTIVE ACTION SHOULD BE				COMPLETION
TAG	` `	R LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE
	twice daily and				care, Should a resident hae a		
	1	ium gumalamant) 40 m a			noted condition change with		
	` •	ium supplement) 40 mg			nausea, vomiting, diarrhea, an	ıd	
	every day.				cognitive changes, said reside		
					will be brought forward for the		
	The nursing con	nprehensive data			review to assist with identificat	tion	
	collection and as	ssessment form, dated			of new interventiosn to be		
	1/4/12, indicated	d Resident #B was alert			implemented, resident/family notification and education, as	well	
		e form indicated the			as MD notification.(4) Monitor		
		ucosa was pink and			systmatic change to ensure		
	moist.	was print and			alleged deficient practice does	;	
	moist.				not recur: The Nurse		
	O 1/5/10 /1 1 1' DMD/D '				managers/designee will be		
	•	aseline BMP (Basic			responsible to review curent		
		) laboratory report for			resident population following a		
	Resident #B, inc	licated the following:			noted condition change of nau and vomiting, diarrhea, and	isea	
	the potassium le	vel was 3.8 (normal range			mental status daily for 14 days	sm	
	3.6-5.1),				wkly for 8 wks, and then 5	,,,,	
	blood urea nitro	gen level was high at 41			random reviews monthly for 6		
	(normal range of	•			months. In addition, the IDT		
	·	vel was high at 1.9			team will review residents with		
	(normal range of	•			noted diarrhea, nausea/vomitii	ng,	
	(normal range of	10.0-1.3).			and/or mental status changes daily Mon thru Fri for 60 days,		
	0 1/6/10 + 1.0	.0 1 1/12/12 .			wkly for 12 wks, and then 5		
		0 p.m., and on 1/12/12 at			random reviews monthly for 6		
	-	ng notes indicated			months to ensure new		
	Resident #B was	s having periods of			interventins are identified and		
	confusion.				implemented for resident care		
					Any identified issue with		
	Dehydration wa	s not identified as a			non-compliance in resident/far notification as per policy and	nily	
	*	11/12, RAI (Resident			procedure will result in 1:1		
	Assessment Inst	· · · · · · · · · · · · · · · · · · ·			re-education and/or disciplinar	v	
					action. The ADM/Designee wil		
	On 1/16/12, the	PD (Pagistarad			responsible to review the resu		
					of the monitoring process and		
	·	sed Resident #B's			forward said reviews to the CO		
		s. The RD's progress			committee for monthly review		
	notes, dated 1/10	6/12, indicated, among			3 quaraters. Any further action	n	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 00	COMPLETED
A. BUILDING B. WING	02/09/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER  2827 NORTHGATE BLVD	
CANTERBURY NURSING AND REHABILITATION CENTER FORT WAYNE, IN 46835	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE  TAG DEFICIENCY)	DATE
other things, that the resident's estimated necessary will be determined by	
daily fluid needs were 3250 ccs to 3900 the CQI committee.	
ccs.	
The RD note indicated the resident's diet	
and fluid at the bedside provided the	
resident's with her estimated fluid needs.	
A nutritional care plan was initiated on	
A nutritional care plan was initiated, on	
1/16/12, and dehydration was not	
identified as an assessed problem but one	
of the nutritional goals was for the	
resident to be free of dehydration.	
The nutritional care plan interventions	
included the following:	
Provide diet as ordered	
Honor food preferences	
Monitor intake of meals and offer	
alternates as needed.	
Vitamins and minerals as ordered	
(multivitamin and potassium),	
Monitor weights,	
Encourage fluids unless contraindicated,	
and	
Monitor labs and monitor for signs and	
symptoms of hypo/hyperglycemia.	
On 1/17/12, a second BMP (Basic	
Metabolic Panel) for Resident # B,	
indicated the resident had elevated	
potassium, BUN and creatinine levels as	
follows::	
the potassium level was high at 5.4	
(normal range 3.6-5.1),	
blood urea nitrogen level was high at 79	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155656	B. WIN	G		02/09/	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ORTHGATE BLVD		
CANTERBURY NURSING AND REHABILITATION CENTER				FORT V	VAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	(normal range of	*					
		vel was high at 3.0					
	(normal range of	£0.6-1.3).					
	On 1/17/12 at 1:4	45 p.m., nursing notes					
	indicated, the Nu	irse Practitioner was					
	notified about the	e abnormal laboratory					
	results and the D	emadex and K-Dur					
	dosages were rec	luced.					
	_						
	Physician orders, dated 1/17/12, indicated						
		as reduced to 30 mgms					
		e Demadex was reduced					
	to 30 mgms twic						
		boratory test was ordered					
	to be done in a w	-					
	to be done in a w	, con.					
	On 1/18/12 at 2:1	20 p.m., nursing notes					
		ident had one loose stool					
	and an episode o						
	and an opisode o	rary neaves.					
	On 1/19/12 at 11	:00 a SBAR					
	physician/nurse						
		and progress note					
		ident's condition had a					
		17/12 and she was					
		reased confusion, an					
		id a decrease in the level					
	of consciousness						
	of consciousness	i.					
	On 1/10/12 tha	Physician ordered a					
		-					
	I -	ergan as needed for odium as needed for					
		odium as needed for					
	diarrhea.						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLETED				
		155656	B. WIN			02/09/2012	
NAME OF P	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE		
CANTER	BURY NURSING A	AND REHABILITATION CENTER			ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	In addition, the resident's orthostatic pulse						
		ire were to be checked					
	1 -	2 hours and the oxygen					
	saturation rates were to be checked every						
	2 hours between 10:00 p.m. and 6:00 a.m.						
	On 1/19/12 at 10:00 p.m., the nursing						
		ne resident returned to her					
	room before eati	ng and stated "I was too					
	sick to stay." She was given Phenergan						
	which was effective. The note indicated						
	fluids were encouraged but taken poorly.						
		indicated "Unable to					
	obtain UA (urina	alysis)-1st spec					
		but not enough urine					
		nen) contam c BM					
		vith bowel movement)"					
		,					
	On 1/20/12 at 10	0:00 p.m., nursing notes					
	indicated the res	ident had a small loose					
	stool and a fall v	vith no injury.					
	On 1/21/12 at 0:	50 a.m., the resident had					
		*					
	_	diarrhea" and Immodium					
	_	note indicated they were					
		the urine specimen e was contaminated with					
	stool.	e was comaninated with					
ı	51001.						
	Care tracker flui	d Intake records between					
	1/17/12 and 1/22	2/12 indicated the					
	resident's daily a	verage fluid intake was					
	1255 cc.						
	Care tracker box	wel reports between					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA						ATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155656	B. WIN	G		02/09/2	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					ORTHGATE BLVD		
CANTERBURY NURSING AND REHABILITATION CENTER				FORT V	VAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION				(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	1/17/12 and 1/22/12 indicated the resident						
	1	diarrhea stools on 1/19/12					
	_	ectively, while nursing					
		he resident had one loose					
		and one loose stools on					
		al of four loose stools					
	recorded in six d	ays.					
	On 1/22/12 at 12	:00 p.m., nursing notes					
		nous fluid were ordered					
	but after three attempts staff were unable						
		The resident's son was					
		e order for intravenous					
		ted to be careful because					
		erienced fluid overload in					
	the intensive care						
		ed a urine specimen was					
		ght catheterization and					
	only "1 vial obta	_					
	1 -	indicated the Nurse					
		notified regarding critical esults and ordered the					
	<u> </u>						
	resident to be tra	-					
	emergency room						
	The BMP (Basic	Metabolic Panel)					
	laboratory report	t, dated 1/22/12, indicated					
	Resident B's:						
	potassium level v	was "panic high" at 6.6					
	(normal range 3.	6-5.1),					
	blood urea nitrog	gen level was "panic					
	high" at 117 (nor	rmal range of 7-18) and					
	`	vel was high at 7.2					
	(normal range of	_					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	JLTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155656	A. BUIL	DING	00	COMPL 02/09/	
		133636	B. WIN			02/09/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID				ID	7,1112, 111 1000	1	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
TAG	The facility trans (no time listed) in loose stools for the level of conscious laboratory test results. Hospital emergent 1/22/12, indicate cardiac arrest emergent arrival at the emergent and a spontaneous than the further she has become of placed her into an hyperkalemia as dysrhythmia"  A hospital consult/22/12, indicate following:  "1. Acute kidney secondary to a condepletion from douse of diuretic the aldactone."  There was no dorresident's dehydre reassessed when along with her presence of the second of the	afer form, dated 1/22/12 Indicated the resident had hree days, a decreased isness, and critical esults.  Incy room records, dated do the resident had a route to the emergency ilseless and apneic upon ergency room. The record ident was intubated and its return of circulation. Indicate "I suspect that dehydrated which has cute renal failure and the cause of her  Itation report, dated do Resident #B had the  Injury and hyperkalemia ombination of volume iarrhea and concomitant erapy, including  cumentation the ration risks were she developed diarrhea reexisting risk factors of		TAG	DEFICIENCY)		DATE
	Tenai disease and	diuretic therapy. In					

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		A. BUILDING  B. WING			COMPLETED 02/09/2012		
		100000	B. WIN			02/00/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			ORTHGATE BLVD VAYNE, IN 46835		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	` `	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	_	h the resident had the					
	following signs o	of dehydration; acute					
	confusion, chang	e in mental status,					
	elevated laborato	ry values and low urine					
	output, there was	no documentation a					
	comprehensive ca	are plan specific to					
	hydration or the	prevention of dehydration					
	was developed.						
	•						
	On 2/9/12 at 10:3	30 a.m., the DON					
	(Director of Nursing) was interviewed.						
	The DON indicated a specific care plan						
		ydration was not					
	-	e nutritional careplan					
	•	The DON indicated they					
	•	•					
		ne exiting nutritional					
	_	viously care planned and					
		nurse practitioner were					
		e resident experienced					
	_	ers were obtained to					
	address each con-	cern.					
		e nutrition and hydration					
		re 4/2010, provided by					
	·	viewed on 2/9/12 at					
	10:00 a.m., and in	ndicated "Monitor the					
	resident for facto	rs that put the resident at					
	risk of dehydration	on. These may include					
	but are not limite	d to:					
	Diarrhea						
	Diuretic medicati	ions					
	Renal disease						
		ctors are identified, new					
	,	l be implemented and					
	interventions will	. co impromented und	1				

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Event ID: VNUZ11

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PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656			A. BUILDING  B. WING			COMPLETED 02/09/2012	
	ROVIDER OR SUPPLIER BURY NURSING A	ND REHABILITATION CENTER		STREET A 2827 NO	DDRESS, CITY, STATE, ZIP CODE DRTHGATE BLVD VAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  CY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
	further assessments. Assess for clininsufficient fluid limited to: Acute confusion Change in mental Deteriorated cognic Elevated laborated Low urine output 7. Implement individuals on residentials.	ical sign/symptoms of intake including, but not  I status nitive status ory values i ividualized interventions					

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Event ID: VNUZ11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155656	A. BUIL	DING	00	02/09/2012	
		199090	B. WIN			02/09/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE  ORTHGATE BLVD		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			VAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0328 SS=D	The facility must receive proper to following special Injections; Parenteral and e Colostomy, urete Tracheostomy caracheal suction Respiratory care Foot care; and Prostheses.  Based on observative record review, th PAP (Positive Aiventilation was pof 3 resident, who airway pressure votations include On 2/7/12 at 11:0 indicated Residerand used a C-PA Airway Pressure)  On 2/7/12 at 11:1 interviewed. Resident to be a using because the mach several months. Secontacted the corrobtained the mach contacted the mach several months. Secontacted the corrobtained the mach contacted the corrobtained the corrobtained the mach contacted the corrobtained	enteral fluids; erostomy, or ileostomy care; are; ing;; ; ation, interview, and he facility failed to ensure inway Pressure) provided as ordered for 2 to had orders for positive eventilation, in a sample of and Resident #B)  :  00 a.m., LPN #10  Int #C was interviewable P (Continuous Positive machine.  15 a.m., Resident #C was sident #C indicated she gater C-PAP machine hine had been broken for She indicated she mpany, where she chine, but they told her as	F03:	28	It is the practice of this facility then sure that residents receive proper treatment and care for special services. (1) Corrective Action for alleged deficient practice: Resident C currently has and is using a c-pap mach under the direction of physicial orders. Resident B no longer resides at the center. (2) Identification of others that has potential to be affected by alled deficient practice: A one-time audit has been completed to review residents with Bi-Pap at C-Pap orders, The Licensed Supervisory staff have been re-educated on providing Bi-Patand C-Pap as per MD order, a policy and procedure. (3) Systematic change to ensure alleged deficient practice does not recur: It is the responsibility the Licensed Supervisory Nursito ensure Bi-Pap and C-Pap treatments are completed as p MD order. The nurse supervisors rydesignee will be supervisors.	nine n /e ged nd ap nd y of se	03/06/2012
	long as she was r	residing in the nursing			responsible to review the		

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	OF CORRECTION  OF CORRECTION  155656  X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:  155656	(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/09/2012	
	PROVIDER OR SUPPLIER RBURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  2827 NORTHGATE BLVD  FORT WAYNE, IN 46835			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
	home they were not responsible for fixing the machine. The resident indicated she did not like using the machine but she felt she needed to use it.  On 2/7/12 at 11:30 a.m., the DON (Director of Nursing) indicated she was not aware Resident #C's C-PAP machine was broken.  On 2/7/12 at 11:40 a.m., accompanied by the ADON (Assistant Director of Nursing) and the Administrator, the C-PAP machine in Resident #C's room was observed. The surface of the machine was dusty, and an oxygen adaptor was missing from the humidifier on the machine. The resident, who was in the room when the C-PAP machine was checked, indicated the mask was also missing.  The Administrator indicated a respiratory therapy company would be notified and would deliver and set up a C-PAP machine for the resident.  The clinical record of Resident #C was reviewed and indicated the resident was admitted to the facility on 3/2/11 with diagnoses which included but were not limited to, diabetes mellitus, chronic obstructive pulmonary disease, sleep apnea and obesity.		provision of Bi-Pap and C-Pap device care and application da for 14 days, wkly for 8 wks, an then 5 random reviews monthly for 6 months. Any identified is with non-compliance in rsident/family notification as popolicy and procedure will result 1:1 re-education and/or discplinary action.(4) The DON/Designee will be responsible to review the result of the monitoring process and forward said reviews to the QAC Committee for monthly review and discussion for 3 months, at then quarterly for 3 quarters. Further action necessary will be determined by the QA committee.	ailly d ly sue er It in  Its A and Any e as	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
ANDILAN	OF CORRECTION	155656	A. BUII		00	02/09/	
		100000	B. WIN		PRESIDENCE CONTROL CON	02/03/	2012
NAME OF F	PROVIDER OR SUPPLIER	8			DRTHGATE BLVD		
CANTER	BURY NURSING A	ND REHABILITATION CENTER			VAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		ated 1/11/12 at 9:30 p.m.,					
		ident was transported to a					
	behavioral health						
		icine Consultation, dated					
		ed Resident #C had					
		ctive Sleep Apnea					
	*	P broken-out pt (patient)					
		NH MD (Nursing Home					
	Medical Doctor)						
		ated 1/17/12 at 8:45 p.m.,					
		ident was readmitted to					
	the facility from	the hospital.					
	Readmission ord	lers, dated 1/17/12,					
		ident was to receive					
		6 cm H2O @ HS (Hour					
	U . /	) 1 L O2 (one liter of					
	oxygen)."	,					
	- 78- 7-						
	1	2, MAR (Medication					
	Administration F	Record) indicated the					
		ion orders were noted but					
		ot provided between					
		re was no explanation on					
		or in the nursing notes					
		ne CPAP ventilation had					
	not been provide						
		12 MAR indicated the					
		on was circled as not					
	1 ^	3/12 and was initialed as					
	provided on 2/4-	7/12.					
	On 2/8/12 at 9·1	5 a.m., LPN #11, who					
		sident #C had received the					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 02/09/2012	
	PROVIDER OR SUPPLIE	L AND REHABILITATION CENTER	STREET . 2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD WAYNE, IN 46835	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	interviewed. LPN #11 indicatuse the C-PAP reshe forgot to circustors she indicated late C-PAP machine hadn't seen it reashe thought the machine because On 2/7/12 at 1:3 Respiratory The had given Resident #C was Resident #C was Resident #C was she indicated as the control of the machine, when she is the control of the control	was in the room but she cently. LPN #11 indicated resident's son took the e it needed to be fixed.  O p.m., CRT (Certified rapist) #13, indicated she lent #C a C-PAP RT indicated it was e resident to use the she was sleeping because			
	indicated a receive Resident #B, has ventilation at night facility.  The closed clinical was reviewed or indicated the restacility from the diagnoses which limited to, chron	11:00 a.m., LPN #10 ntly discharged resident, d received BI-PAP ght when she was in the cal record of Resident #B n 2/7/12 at 2:30 p.m., and ident was admitted to the hospital on 1/4/12, with a included but were not ic biventricular failure, and obstructive			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED
		155656	B. WIN			02/09/2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	
CANTED		ND DELLABILITATION OF NITED			ORTHGATE BLVD	
CANTER	BURY NURSING A	ND REHABILITATION CENTER		FORTV	VAYNE, IN 46835	
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)	DATE
	sleep apnea.					
	TT 1. 1. 1. 1.					
	_	charge summary, dated				
		the resident received				
		Airway Pressure (BIPAP)				
	with supplement	al oxygen in the hospital.				
	•	on orders, dated 1/4/12,				
		+ O2 (Continuous				
	positive airway pressure plus oxygen).					
		CPAP was not noted on				
	the 1/4/12, admis	ssion POS (Physician				
	Order Sheet) or o	on the January 2012				
	MAR/TAR (Med	dication/Treatment				
	Administration F	Records) . There was no				
	documentation o	n the MAR/TAR to				
	indicate the C-PA	AP ventilation was				
	initiated until 1/1	0/12 (6 days after				
	admission).					
	On 1/4/12 at 8:00	p.m., nursing notes				
	indicated the resi	ident's lung sound were				
		he stated she could not				
	lay down flat in l	bed, could not breathe				
	*	erate the CPAP at the				
	Hospital.					
	On 1/6/12, Nurse	e Practitioner notes				
	· ·	ident had difficulty				
	sleeping and was					
	BiPAP-"unable t					
	There was no do	cumentation the CPAP				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE SURVEY COMPLETED 02/09/2012	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET A 2827 N	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD WAYNE, IN 46835	ı
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
	to clarify the CPA pressure settings or that a CPAP n	hat attempts were made AP orders (to obtain the and oxygen flow rates) hachine was set-up or me of admission.			
		00 p.m. (4 days after ing notes indicated, to obtain CPAP			
	indicated the phy pressure setting f Positive Air Pres	40 p.m., nursing notes visician called with the for a BIPAP (Bilevel sure) machine and "resp e out c (with) machine."			
	*	, dated 1/10/12, indicated on at HS (Hour of Sleep) - 10/4."			
	indicated the BIF	:00 p.m., nursing notes PAP machine was as on while the resident			
		sician's order indicated, ap c (with) 3 1 O2 (three"			
	interviewed. LPN	0 p.m., LPN #10 was N #10 indicated a family to the facility a few days			

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00			COMPLETED	
		155656	B. WIN	G		02/09/2	012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
CANTED		ND DELIABILITATION OFNITED			ORTHGATE BLVD		
CANTER	BURY NURSING A	ND REHABILITATION CENTER		FORTV	VAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	BEFELECT	+	DATE
		B's admission and noticed					
	a (PAP) machine was not in the room.						
		ber told her it was					
		he resident use the					
	1	and they needed to call					
		nonologist to get the					
	settings.						
	On 2/8/12 at 3:30	0 p.m., RN #12, who					
	admitted Resident #B on 1/4/12, was interviewed. RN #12 indicated she called the respiratory therapy company after						
		admitted and they					
		eded to get the (PAP)					
	settings before th	• , ,					
		licated Resident #B said					
		ear the CPAP machine so					
	she did not follo						
	clarification orde	-					
		e received a disciplinary					
		t following up on the					
	CPAP orders on	• •					
	314015 011	· <b></b> ·					
	1 2	on-Invasive ventilation					
	(Continuous Pos	•					
	Pressure/Bilevel	_					
	Pressure, revised	1/2009, provided by the					
	DON, was review	wed on 2/8/12 at 4:30					
	p.m., and indicat	ed "Respiratory Therapist					
	and/or nursing po	ersonnel trained to					
	perform and care	e for the CPAP/BiPAP					
	dependent reside	ent will perform					
	equipment setup	, monitoring, and					
	troubleshooting a	as per physician's order					

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PRINTED: 03/19/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155656	A. BUILDING  B. WING	COMPLETED 02/09/2012
	PROVIDER OR SUPPLIER BURY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STA 2827 NORTHGATE BLV FORT WAYNE, IN 4683	/D
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE	AN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)  (X5)  COMPLETION DATE
	Verify physician's order including: amount of pressure and duration of use Amount of supplemental oxygen Mask size"		
	This Federal tag relates to Complaint IN00103433.		
	3.1-47(a)(6)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	00	COMPL	
		155656	B. WIN	G		02/09/	2012
CANTER		ND REHABILITATION CENTER		2827 NO FORT V	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD WAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCE		DATE
F0514 SS=D	SSIBLE The facility must each resident in professional star complete; accura accessible; and accessible; and accessible; and accessible; and accessible; and service preadmission so State; and programmer and document the omission. This direction and document the omission. This direction accession acceptation acceptati	ation, interview, and the facility failed to follow fircle omitted treatments the reason for the the efficiency affected 1 of 5 treatments were the mple of 5.	F05	14	It is the policy of this facility to circle omitted treatments and document the reason for the omission.(1) Corrective action taken for resident affected by alleged deficient practice: A audit was completed to ensure circled medications or treatme have been addressed to ensur policy and procedure has been followed for documenting the reason for any omissions.(2) Identification of other residents have potential to be affected be alleged deficient practice: A of time audit was completed on current resident population to ensure circled medications or treatments have been address to ensure policy and procedure have been followed for documenting the reason for an omission.(3) Systematic Changto ensure alleged deficient practice does not recur: Staff have received re-education	e nts re n s to by ne	03/06/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPL	ETED
		155656	A. BUII B. WIN			02/09/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	8			ORTHGATE BLVD		
CANTED		ND REHABILITATION CENTER			VAYNE, IN 46835		
CANTER	BURT NURSING A	IND REHABILITATION CENTER		FORT	VATNE, IN 40833		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 2/7/12 at 11:4 the ADON (Assi Nursing) and the C-PAP machine was observed. The was dusty, and a missing from the machine. The restroom when the Cochecked, indicated missing.  The clinical recorreviewed on 2/9/indicated the restraction of the company of the c	40 a.m., accompanied by stant Director of Administrator, the in Resident #C's room he surface of the machine in oxygen adaptor was humidifier on the sident, who was in the C-PAP machine was ed the mask was also ard of Resident #C was 12 at 11:45 a.m., and ident was admitted to the la, with diagnoses which he not limited to, diabetes to obstructive pulmonary			regarding the policy/procedure for documenting omission of medication or treatments. The nurse managers are responsit to review the medication and treatment records daily for 14 days, wkly for 8 wks, and then random reviews monthly for 6 months. Any identified issue wnon-compliance will result in 1 education and/or disciplinary actions.(4)Monitoring of Systematic Change to ensure alleged deficient practice does not recur: The DON/designee monitor the results of the daily audits and forward the information to the CQI commit for discussion monthly for 3 months and then quarterly for quarters. Any further action necessary will be as determine by the CQI committee.	ole  5  vith :1  will  tee	
	C-PAP readmiss were circled as n	ion orders were noted but					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		(X2) MULTIPLE CC A. BUILDING B. WING	00	(X3) DATE COMPL <b>02/09</b> /	ETED	
	PROVIDER OR SUPPLIER	ND REHABILITATION CENTER	STREET A 2827 No	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD WAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	why the C-PAP or provided on the land (Medication/Treat Records) or in the The February 20 C-PAP ventilation provided on 2/1-provided on 2/4-On 2/8/12 at 9:13 had initialed Rest C-PAP ventilation interviewed.  LPN #11 indicate use the C-PAP make forgot to circum on 2/7/12 at 11:1 interview with Reace bandages we walker. Resident edge of her bed, on her legs. She area on her left left. The February, 20 Administration February 20 Administration February 20 Administration February 20 Administration February 21 Administration February 21 Administration February 21 Administration February 22 Administration February 23 Administration February 24 Administration February 25 Administration February 26 Administration February 26 Administration February 27 Administration February 26 Administration February 27 Administration February 27 Administration February 27 Administration February 28 Administration February 28 Administration February 29 Administration February 20 Administration Februa	wentilation was not MAR or TAR atment Administration e nursing notes.  12 MAR indicated the on was circled as not 3/12 and was initialed as 7/12.  5 a.m., LPN #11, who ident #C had received the on on 2/5-7/2012, was ed the resident did not nachine on 2/5-7/12 and let the entry.  15 a.m., during an esident #C, two rolled re observed on top of her #C was sitting on the and she had no ace wrap had a quarter sized red ower leg.  112 TAR (Treatment Record) was reviewed on .m., and indicated the ave ace elastic bandage "Toes to Knees-May Hours Sleep) on daily. ed the Ace wraps had 2/7/12. The TAR				
	indicated the Res	sident #C was to have a				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155656		(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE S COMPLI 02/09/2	ETED	
	PROVIDER OR SUPPLIER	L ND REHABILITATION CENTER	STREET A 2827 No	ADDRESS, CITY, STATE, ZIP CODE ORTHGATE BLVD NAYNE, IN 46835		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
		ng applied daily to a g. The Xeroform dressing one on 2/7/12.				
	(Director of Nursand indicated the on when she chea.m. on 2/7/12. Streatment was so night shift and sh	45 a.m., the DON sing) was interviewed acce wrap had not been cked the resident at 8:00. She indicated the heduled to be done on the ne would check with the see if the treatments had				
	had signed that F and ace wrap had was interviewed. LPN #11 indicate early morning, the well so she did no wrap. She indicate the treatments we	ed on 2/7/12, during the ne resident did not feel ot do the treatment or ace ted she had signed that here done earlier and he treatments on the TAR				
	area on the left le					
	administration, re	evised 7/2010, provided rector of Nursing), was				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLI	E CONSTRUCTION		TE SURVEY  IPLETED	
ANDILAN	OF CORRECTION	155656	A. BUILDING	00		09/2012
		100000	B. WING		_	7572012
NAME OF F	PROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZI 7 NORTHGATE BLVD	IP CODE	
CANTER	BURY NURSING A	ND REHABILITATION CENTER		RT WAYNE, IN 46835		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO TO DEFICIENCY	HE APPROPRIATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENC I	()	DATE
		12 at and indicated				
		e following as applicable:				
		n of medication on the				
	,	on Administration				
	·	as medications are given. ed or omitted dose by				
	block	ials in the appropriate				
	c. Indicate the re	ason for omission on the				
		notes or on the back of				
	the MAR."					
		00 a.m., the DON				
		ility did not have a				
		re for the administration				
	of treatments and					
		inistration applied to				
	treatment admini	istration as well.				
	3.1-50(a)(1)					

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